

Addressing the psychosocial needs of genital herpes sufferers

Improved patient management must be a priority if we are to reduce the adverse consequences that genital herpes may have on affected individuals and also the contribution this common cause of genital ulceration makes to the transmission of HIV infection.

Many patients experience frequently recurring episodes from the life-long infection which follows first episodes. It has long been recognised that psychological factors, such as emotional stress, can trigger recurrences. In addition, it is clear that the diagnosis of herpes brings with it a psychological burden which impinges on normal social and sexual functioning.^{1,2} Patients feel controlled by the virus and are often afraid to discuss their predicament with partners and friends for fear of derision and rejection.³

To provide effective management of genital herpes, physicians must address both the medical and psychosocial needs of their patients. At the first diagnosis of genital herpes, patients should be educated about the nature, features and transmission of their infection and individually assessed to determine its likely psychosocial impact. Similarly, patients with frequently recurring or severe disease often need additional counselling and support as part of their overall disease management.

Effective reassurance and counselling, together with optimal medical management of symptoms, can help to reduce the frequency of recurrences and allow patients relief from the psychological distress of genital herpes.^{4,5} Clearly, in patients whose quality of life is significantly impaired by frequent recurrences, suppressive treatment with acyclovir can provide effective control of symptoms.⁶ However, the use of antiviral treatment should be as an adjunct to patient education, counselling and support rather than as a replacement for it.

Patient denial, lack of knowledge and inadequate counselling contribute to spread of disease. It is essential that consultations provide sufficient time to counteract these problems. Educational sessions can also help patients with subclinical infection to identify manifestations of recurrences, when the risk of transmission to sexual partners is greatest.⁷

Both primary care and specialist physicians are involved in managing patients with genital herpes, and depending on the particular health care system in operation, the job of counselling and providing psychological support may fall to the physician or to another trained health-care professional. Whatever the division of labour between health-care professionals, it is essential that those at the first point of contact with patients do not overlook the psychological needs integral to the disease and its management. In genitourinary medicine clinics, this requirement should be considered as a measure of service quality which has important planning and resource implications.

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Aphthous ulcers in HIV-infected patients: treatment with thalidomide

Aphthous ulcerations in HIV-infected persons can be severe and persistent.¹ They may involve the genital area, gastrointestinal tract, as well as the mouth and pharynx. Ulcerations caused by fungal, bacterial or viral agents and malignancy must be excluded before idiopathic aphthous ulcerations are considered.

In recurrent aphthous ulcers, immunosuppressive and cytotoxic agents are often used, but these agents may be dangerous in already debilitated patients. We report a case of an HIV-infected patient with aphthous ulcers which dramatically improved within 48 hours of thalidomide treatment.

A 25 year old homosexual man, HIV1 antibody positive since 1988, was admitted in 1992 for fever, discrete generalized erythema, dysphagia, pharyngitis and myalgia. Clinical examination showed oral aphthous ulcers, bilateral conjunctivitis and painful aphthoid ulcerated lesions of the scrotum (2-3 cm diameter) (fig). Mild inguinal, axillary and cervical lymphadenopathy was present. No evidence of viral, bacterial or fungal infection



Figure Large painful aphthous ulcer of the scrotum.

was seen. Biopsy specimens showed a polymorphic infiltration of the dermis without necrosis. Stains for bacterial or fungal infection and cultures for virus and mycobacteria were negative. Thalidomide was administered (100 mg twice a day) and the patient dramatically improved within 48 hours of treatment. Thalidomide was interrupted 6 days after the beginning of treatment because of transient paraesthesias and pain involving the four limbs. Clinical examination disclosed sensory and motor peripheral neuropathy, confirmed by electromyogram with decreasing motor conduction in the four limbs. The CSF yielded a lymphocytic aseptic meningitis. Neurologic abnormalities spontaneously regressed one month later.

Thalidomide is of value in the treatment of many skin conditions including genital ulcerations and should be tried for resistant aphthous ulcers in HIV-infected patients.² Most of the side effects of thalidomide therapy are minor including fatigue, constipation, nausea and dry skin. Hypersensitivity reactions (fever, erythematous macular rash) have been recently reported in three HIV-infected patients who received thalidomide for aphthous oropharyngeal ulcerations.³ The side effects of thalidomide seem to be more severe and less tolerated in HIV-infected patients.

Another major complication is neuropathy which is dose dependent,⁴ of an axonal type affecting mainly sensory fibres of the lower limbs. Usually motor conduction changes are not found. In our patient neuropathy cannot be attributed to thalidomide because of the short period before occurrence, motor conduction changes and CSF abnormalities. His neuropathy may have been due to the HIV-infection itself.

As the benefits greatly outweigh the risks of side effects of thalidomide treatment, especially compared with other possible regimens, this medication should be considered for the treatment of genital and aphthous ulcers before immunosuppressive agents like corticosteroids in the treatment of HIV-infected patients.

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HIV infection and menstrual abnormalities

The number of women infected by human immunodeficiency virus (HIV) is increasing.¹ The incidence of lower genital tract intra-epithelial neoplasia and infection has been well documented.^{2,3} There are, however, few data on menstrual abnormalities in these women. Reports of an increased prevalence of amenorrhoea⁴ need further evaluation since factors such as substance misuse, prescribed drugs such as methadone and weight loss can significantly affect the menstrual cycle. Possible HIV-related causes include premature ovarian failure, secondary to opportunistic infections such as cytomegalovirus⁵ or autoimmunity resulting from the polyclonal gammopathy associated with HIV infection.⁶

To assess the prevalence of menstrual dysfunction in HIV seropositive women a retrospective analysis was performed of the menstrual histories from women attending two genitourinary clinics in London. Those patients who were pregnant, post menopausal or on hormonal contraception were excluded from analysis. Of the 58 women remaining, 42 (72.4%) had regular menstrual cycles, 10 (17.2%) had oligomenorrhoea and six (10.4%) had amenorrhoea. Analysis of these data revealed that of the women with amenorrhoea, two were current intravenous drug users and four were on methadone maintenance. Similarly, of the women with oligomenorrhoea, two were current intravenous drug users, four were on methadone maintenance and three were taking cocaine.

Our findings initially suggested a higher prevalence of amenorrhoea and oligomenorrhoea in HIV seropositive women in comparison with the general population.⁷ However, this difference is not sustained once substance misuser's and patients on methadone maintenance have been excluded. The number of women with severe immunosuppression (CD4 < 200) in this study was less than 10% and symptomatology may change as increasing numbers of women survive prolonged periods of immunosuppression. A continuing long term prospective study of this subject, with case matched controls is currently being performed.

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